DRN-5144165

The complaint

Mr and Mrs H are unhappy with the time it took for Legal and General Assurance Society Limited to pay their critical illness claim. They're also unhappy with the service and settlement they received.

Although this is a joint policy, the claim itself is for Mr H and so I'll refer to all submissions as being made by him personally.

What happened

Mr H made a claim for total and permanent disability in September 2023. A year earlier, he seriously injured his back, which he said was made worse following a session with his chiropractor. Mr H was diagnosed with prolapsed discs in his spine, which were fractured following the session with his chiropractor. Mr H was also diagnosed with osteoarthritis and osteoporosis in June 2023.

Mr H said L&G took too long to consider his claim. He said it took around 18 months for L&G to pay his claim which severely impacted his life and unnecessarily prolonged his pain and suffering. Mr H said L&G had everything it needed to make the decision to pay his claim much earlier than it did. He also described losing his family's home because of L&G's poor handling of his claim. Mr H explained he was left with serious mental health issues, including depression, anxiety and was left feeling suicidal. Mr H had a decreasing term assurance policy and said that because L&G took too long to accept his claim, he received less benefit as a result.

Mr H would like L&G to pay that difference and pay compensation for the severe trauma he said this experience left him with.

L&G said it disagreed with the chronology given by Mr H. It explained it took around seven months to validate his claim as it was only notified of his total and permanent disability claim in September 2023 and approved it in April 2024. L&G said there were some delays in handling Mr H's claim, however, that the majority were driven by third parties, such as Mr H's GP surgery and having to wait for medical evidence from his treating specialists. In recognition of the poor service it provided Mr H, L&G offered him £200 compensation.

Our investigator partially upheld Mr H's complaint. She found L&G had caused unnecessary delays throughout the claims process and said that it didn't proactively chase for medical evidence, such as GP records in good time. She recognised the serious impact the delays had on Mr H's complex health and issues overall and recommended it increase its compensation offer to £600 for the distress and inconvenience caused. Our investigator didn't find that L&G were responsible for Mr H having to sell his family's home, nor did she agree L&G should increase the benefit amount it paid as settlement for the claim.

Both parties disagreed with her recommendations. L&G felt the offer of £200 compensation was fair and so didn't agree to the recommended increase. Mr H, also unhappy with the compensation, said it was derisory. Mr H made several arguments in response to our investigator's findings, in summary, he said;

- He was awarded government scheme personal independence payments (PIP) in May 2023 and that this should have been enough evidence for L&G to accept his claim, without the need for additional medical evidence;
- He provided L&G with all the medical evidence needed to prove his disability, including an MRI scan from April 2023 which showed the fractures to his spine;
- He's been left with serious mental health issues following this experience with L&G and he doesn't believe L&G has taken responsibility for that;
- L&G unfairly expected him to chase for the outstanding medical evidence and caused him unnecessary distress by threatening to cancel his claim should he fail to gather and present that evidence;
- L&G failed to inform him he could apply for a waiver of premiums after he'd made his claim. He explained this caused him significant financial worries unnecessarily and;
- L&G didn't pay the associated costs for releasing the GP records until March 2024, which caused additional delays with paying his claim.

And so, it's now for me to make a final decision.

What I've decided – and why

I've considered all the available evidence and arguments to decide what's fair and reasonable in the circumstances of this complaint.

Having done so, I've also decided to partially uphold it and for the same reasons as previously explained by our investigator. Whilst I recognise Mr H's claim was complex and L&G, for the most part, handled things well. There were still issues that arose which weren't handled as well. I understand L&G disagreed with the recommended compensation, however, I think it's fair given the individual circumstances of Mr H's complaint. I also recognise Mr H will be unhappy with my decision as he wants L&G to pay more compensation. And so, I'll explain why I think our investigator's opinion is fair.

Before I go to do that, I wanted to acknowledge the serious difficulties Mr H has experienced over the last couple of years. I'm sorry to learn about the issues he, and his family, have endured and I've considered his vulnerability throughout my assessment of his complaint. That's to say that his vulnerability, in my view, has persuaded me that he's perhaps more susceptible to a greater impact where things have gone wrong. I thought it helpful to highlight that here for L&G's benefit as I think it'll help aid its understanding of why I believe some of its errors have had a considerable impact on Mr H.

There's a wealth of arguments made by Mr H, all of which I've considered, however I don't intend to address each point in my final decision. The powers given to me as an ombudsman allow me to do that. Therefore, I'll only be commenting on those I believe are central to the outcome of his complaint against L&G.

The relevant rules that L&G has to follow when assessing Mr H's claim are from the insurance code of business source book (ICOBS). These rules say L&G must assess claims promptly and fairly, and not avoid a claim. I've considered its obligations under ICOBS whilst considering Mr H's complaint.

The policy terms say about TPD;

"Total and permanent disability – unable to do three specified work tasks ever again. Loss of the physical ability through an illness or injury to do at least three of the six work tasks listed below ever again. The relevant specialists must reasonably expect that the disability will last throughout life with no prospect of improvement, irrespective of when the cover ends or the

life assured expects to retire.

The life assured must need the help or supervision of another person and be unable to perform the task on their own, even with the use of special equipment routinely available to help and having taken any appropriate prescribed medication"

The specified work tasks are;

"Walking: The ability to walk more than 200 metres on a level surface.
Climbing: The ability to climb up a flight of 12 stairs and down again, using the handrail if needed.
Lifting: The ability to pick up an object weighing 2kg at table height and hold for 60 seconds before replacing the object on the table.
Bending: The ability to bend or kneel to touch the floor and straighten up again.
Getting in and out of a car: The ability to get into a standard saloon car, and out again.
Writing: The manual dexterity to write legibly using a pen or pencil, or type using a desktop personal computer keyboard.

For the above definition, disabilities for which the relevant specialists cannot give a clear prognosis are not covered"

Mr H claimed for total and permanent disability (TPD) in September 2023. I understand he became unwell with his symptoms of back pain a year earlier, however, in an attempt to treat those symptoms, further and more serious damage was done to his spine. Mr H was diagnosed with fractures in his spine following a chiropractor session. It transpired Mr H was also diagnosed with osteoporosis and osteoarthritis in June 2023 and that the presence of this undiagnosed, and therefore unknown condition, could've contributed to the outcome of the treatment received from his chiropractor.

Since then, Mr H had been experiencing severe levels of pain and had been taking strong opioid medication to help manage his symptoms. The evidence I've seen supports that Mr H, even whilst taking his medication, was still incapacitated and unable to look after himself independently. Mr H described being unable to walk, bend or even write due to his symptoms of severe pain. Mr H has been cared for by his wife and daughter.

Mr H had been off work since September 2022 and wasn't in receipt of sick pay from his employer. He fell into financial difficulty and eventually had to sell his home as he could no longer afford the mortgage repayments. Mr H made several arguments about this being L&G's responsibility. In summary, Mr H said had L&G paid his claim sooner, then he wouldn't have had to sell his property because the benefit amount would've paid his remaining outstanding mortgage. But I'm not persuaded that's the case. I say that because the evidence I've seen shows Mr H's money problems began to manifest following his absence from work, which was almost a year before he made his claim for total and permanent disability with L&G.

I also note Mr H submitted a claim for PIP, which was accepted in May 2023, some four months before he claimed with L&G.I also note that Mr H sold his property in mid-September 2023 which was around two weeks before he notified L&G of his intention to make a claim for permanent and total disability. Therefore, I disagree that L&G's actions bore any impact on Mr H having to sell his home as this all took place prior to its involvement.

Mr H argued that L&G should've accepted his claim sooner than it did based on the outcome of his PIP assessment, but I disagree with that too. The PIP initiative is a government-backed scheme. That's to say it's a different set of criteria that needs to be met in order to meet the claim. Typically, a TPD claim with an insurer is a more involved assessment and

usually involves significantly higher benefit amounts. In any event, its L&G that sets the criteria for that within its policy terms. I should say that it's a high bar to satisfy the TPD and typically is a lengthy claims process.

Mr H is unhappy with the time it took for L&G to make a decision on his claim, and I agree, there were some inefficiencies which extended the period he had to wait unnecessarily. But Mr H needed to prove, through medical evidence, that he was totally and permanently disabled – meaning he'd never recover from his injuries. This was challenging because although Mr H was clearly incapacitated, there wasn't enough persuasive medical evidence available to suggest Mr H was permanently disabled. I say that because the evidence I've seen shows that Mr H was still undergoing different treatments with the specialists involved with his care when he brought his claim in September 2023.

In November 2023, the medical evidence shows that Mr H was still receiving pain relief injections every six months. L&G's case notes show it wanted to wait and consider how that could potentially impact Mr H's osteoporosis – which I think was reasonable as L&G suggested there was a chance his symptoms could improve.

I also note Mr H had been referred to an orthopaedic specialist and a urologist which didn't happen until February 2024. And so, I'm persuaded by what L&G said about it perhaps being too premature to consider his claim for TPD given Mr H's medical evidence suggested his treatment was still on-going at that point. I think that's an important point given the policy terms say Mr H's disability must be permanent – meaning there's no prospect of a recovery. I'm persuaded by the evidence that it wasn't until February 2024, following an appointment with his orthopaedic specialist, that Mr H's prognosis showed his condition was permanent.

Did L&G communicate effectively and were the delays unnecessary?

I've thought carefully about L&G's role here, in particular, what it said to Mr H and how it managed his expectations. This is where I think L&G could've done more as I don't think it explained to Mr H, in any meaningful way, that he'd effectively brought his claim too early. I note there were comments within L&G's submission which I'm persuaded showed this was a consideration at different times throughout the claim. However, it didn't share that with Mr H. I think had it taken the time to explain this to Mr H, it would've helped him to better understand what was required and better managed his expectations.

In February 2024, after reviewing the available medical evidence, L&G noted that although Mr H and his GP had explained he was unable to complete several tasks unaided, there was no commentary on their permanence. This, alongside the disclosure that Mr H was awaiting orthopaedic and urology input, as well as undergoing physiotherapy meant it was effectively still too premature to accept his claim. But L&G didn't explain this plainly to Mr H. Instead, it explained it was still waiting for additional medical evidence as the GP's notes were incomplete. I accept the GP records were incomplete, but that wasn't the only issue at that time and I expect had L&G been clearer about that, it would've helped Mr H better understand the reasons for some of the delays.

The issue with obtaining the GP records was particularly frustrating for both Mr H and L&G. I agreed with everything our investigator said about that. I'm satisfied the GP surgery caused some of the delays, however, I think L&G should've done more to gather this information more quickly. I say that because I'm satisfied Mr H made it clear that he was suffering, not only financially, but emotionally too. I won't go into detail about that here as both sides are aware of the difficulties Mr H has had to deal with. I think it's fair to say Mr H was contacting L&G excessively having sent more than 40 emails in an attempt to get his claim over the line. I appreciate not all of those emails were directly addressed to L&G, however, I think it goes some way to show that Mr H was desperate and significantly struggling throughout the

life of the claim. And so, I think L&G should've been more proactive when trying to gather the necessary medical evidence from the GP.

Our investigator noted that there were periods where L&G weren't actively pursuing the missing medical evidence. L&G's response to that was that it has service level agreements which permit it to wait four-weeks before chasing for outstanding information. However, given Mr H's vulnerability evidenced by his testimony and his desperate pattern of communication, I think L&G could've adapted and prioritised this. I think that would've reduced the level of distress this was causing Mr H. I accept L&G cannot be held responsible for any issues at the GP surgery, but it could've handled this better in the way I've just explained.

I note L&G spoke with Mr H's GP surgery in an attempt to locate the missing medical records and it was suggested this could potentially be held by the Local Health Authority. Had that been the case, it could've significantly impacted the time to validate Mr H's claim as retrieving medical records in this way is typically lengthy. However, I noted L&G missed the opportunity to instruct the surgery to take that action during that interaction, which further persuaded me that L&G's communication wasn't as effective as it could've been and caused unnecessary delays of around one month.

I also recognise this is in addition to the delays caused at the beginning of Mr H's claim as after L&G received Mr H's claim (at the beginning of October 2023) it didn't take any action until the end of that month. Further, Mr H's GP invoiced L&G on 20 December 2023 to release the medical information, however, it didn't pay the fee until almost three weeks later. L&G was invoiced for another fee to release additional information related to the case in March 2024 and took almost two weeks to pay that invoice. It then had to wait around another three weeks for that information, however, it didn't proactively chase for it at any point – which given what I've already explained prioritising Mr H's claim based on his vulnerabilities feels unfair in the circumstances.

I should be clear these are service-related issues and although L&G eventually paid the claim, I think it could've been more sympathetic to Mr H's needs given his well-documented vulnerabilities and adapted where appropriate to better meet his needs.

Mr H made other arguments about L&G causing his significant distress and worry because it threatened to effectively cancel his claim if he didn't respond to it. But the evidence I've seen persuaded me that's not the case. Mr H has another policy with L&G for waiver of premiums should he become too unwell to work. The communication he's referring to is about that policy and not the TPD claim. I've reviewed the relevant documents and I'm satisfied they're clear about that. I also note that policy had a 26-week deferred period prior to being able to make a claim for that cover.

Mr H's argument that L&G didn't actively make him aware that he could bring a claim for the premium waiver isn't persuasive. I say that because Mr H still brought his claim for that in good time – a month before that deferred period expired. And so, I'm satisfied it makes little difference whether L&G proactively told him there was cover for that given he still brought a claim in time, which L&G accepted.

Was the settlement amount fair?

Mr H said the settlement amount he received once his claim for TPD was accepted was unfair. To be clear, I understand the arguments he's making about that – had L&G accepted his claim earlier than April 2024, then he'd have received a higher amount of settlement. I've carefully considered that, however, I don't think L&G needs to do anything more in the circumstances. The reason I say that is because although L&G accepted his claim then, it

also backdated the settlement to January 2024. It did that because this was the point from where the medical evidence supported he was unable to perform at least three of the six tasks as described by his policy.

Further, the medical evidence that was received over the two months that followed persuasively demonstrated there wasn't any likely possibility Mr H would recover from his condition. And so, L&G said it considered all this evidence in the round and decided to accept liability for his claim.

And so, whilst I agree L&G delayed things here, I still think it did the right thing by backdating Mr H's claim to January 2024 for these reasons as the GP records showed he was unable to perform the necessary tasks to qualify for benefit.

My final decision

For the reasons I've explained, I'm partially upholding Mr and Mrs H's complaint and Legal and General Assurance Society Limited must pay £600 compensation for the considerable distress and inconvenience caused.

Under the rules of the Financial Ombudsman Service, I'm required to ask Mrs H and Mr H to accept or reject my decision before 20 March 2025.

Scott Slade
Ombudsman